STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING _____ B. WING _____	C 05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF BOONVILLE	**725 S SECOND ST BOONVILLE, IN 47601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00198413 and Complaint IN00198802. Complaint IN00198413 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00198802 - Substantiated. No deficiencies related to the allegations are cited. Survey date: May 5, 2016 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Census bed type: SNF/NF: 64 Total: 64 Census payor type: Medicare: 13 Medicaid: 44 Other: 7 Total: 64 Sample: 6 Transcendent Healthcare of Boonville was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00198413 and Complaint IN00198802. QR was completed by 99993 on 05/06/16.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE